New Jersey Department of Health and Senior Services Refugee Health Program PO Box 369, Trenton, NJ 08625-0369

DOMESTIC HEALTH ASSESSMENT

After completion, mail form to the address provided above.

| Name (Last) (First) (Middle) Gender Male Female Alien Number Street Address U.S. Arrival Date J. Country of Origin | SECTION I | | | | | | | | | |
|--|---|---------------------------------|-------------------------------------|--------------------|---------------------|-------------------|---------------------|----------------|--|--|
| Street Address | Name (Last) | (First) | | | Gender | | Alien Number | dien Number | | |
| City, State, Zip Code Date of Birth | | | | | | Female | | | | |
| County Telephone Number Primary Language Spoken Sponsor Agency PRIOR MEDICAL HISTORY Overseas Class A/Class B Conditions Identified: | Street Address | US Arrival Date | | Country of Origi | untry of Origin | | | | | |
| County Telephone Number Primary Language Spoken Sponsor Agency PRIOR MEDICAL HISTORY Overseas Class A/Class B Conditions Identified: | | | 1 | 1 | , , | ountry of origin | | | | |
| County Telephone Number Primary Language Spoken Sponsor Agency PRIOR MEDICAL HISTORY Overseas Class A/Class B Conditions Identified: | City State Zin Code | | Date of Birth Country of Birth | | | | | | | |
| PRIOR MEDICAL HISTORY Overseas Class A: Class B: Conditions Identified: Yes No | Only, Grato, Elp Godo | | I I | | | | | | | |
| PRIOR MEDICAL HISTORY Overseas Class A: Class B: Conditions Identified: Yes No | County | Tolonhono Numbor | Drimony Location Connect Activities | | | | | | | |
| Overseas Class A/Class B Conditions Identified: | County | elephone Number | - - | nary Language | Spoken Sponso | n Agency | | | | |
| Overseas Class A/Class B Conditions Identified: | | | | | | | | | | |
| Class A: | O Ola | D O - - - - - - - | | | IISTORY | | | | | |
| Class B2/TB: Clas | | | | | | | | | | |
| Class B1/TB Class B2/TB: Class BVOther: | | | | | | | | | | |
| Class B/Other: SECTION II - TO BE COMPLETED BY EXAMINING HEALTH CARE PROVIDER IMMUNIZATION RECORD | | | | | | | | | | |
| SECTION II - TO BE COMPLETED BY EXAMINING HEALTH CARE PROVIDER IMMUNIZATION RECORD NOTE: if vaccine status is listed on form, it has been transcribed from overseas arrival form at DHSS. Begin or update vaccines; non-US born need the same age appropriate vaccines as other patients. Refer to and follow the DHSS childhood and adult vaccine schedule. When no vaccine documents, vaccinate. Provide patient written vaccine record and the federally required VIS. "Varicella history, patient or parental fecall, or physician documentation of disease. VACCINE TYPE MODAYYR MO | ☐Class B2/TB: | | | | | | | | | |
| MMUNIZATION RECORD | ☐Class B/Other: | | | | | | | | | |
| MMUNIZATION RECORD | | SECTION II - TO | BE COMPLET | TED BY EXAM | INING HEALTH | CARE PROVI | DER | | | |
| born need the same age appropriate vaccinate. Provide patients. Refer to and follow the DHSS childhood and adult vaccine schedule. When no vaccine documents, vaccinate. Provide patient written vaccine record and the federally required VIS. *Varicella history, patient or parental recall, or physician documentation of disease. VACCINE TYPE 1ST DOSE 2ND DOSE MO/DAYYR MO | | | | | | | | | | |
| When no vaccine documents, vaccinate. Provide patient written vaccine record and the federally required VIS. *Varicella history, patient or parental recall, or physician documentation of disease. VACCINE TYPE 1ST DOSE 2ND DOSE MO/DAYYR MO/DAYY | NOTE: if vaccine stat | us is listed on form, it | has been transci | ribed from overse | eas arrival form at | DHSS. Begin or | update vaccines; | non-US | | |
| VACCINE TYPE | | | | | | | | | | |
| WACCINE IYPE MO/DAY/R MO/DAY/C MO | | | | niteri vaccine rec | ord and the reder | any required vis. | varicella filstory | , patient or | | |
| DTP/DTaP/Td/TD (If Td or DT, indicate in corner box) DPV/IPV (If oral vaccine, indicate OPV in corner box) MMR HAEMOPHILUS B (HIB) VARICELLA PNEUMOCOCCAL CONJ. OTHER (Specify): LEAD SCREENING (5 6 Years) TEST DATE: RESULT: RESULT: RUBBIA Mumps HEPATITIS B VIRUS (HBV) SCREENING Mumps HEPATITIS B VIRUS (HBV) SCREENING Measles Mumps HEPATITIS B VIRUS (HBV) SCREENING TUBERCULOSIS SCREENING HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Not given Reason: Not given Reason: TB Treatment (*\fone): Yes Not Done | VACCINE TYPE | | | | | | MO/DAY/YR | MO/DAY/YR | | |
| indicate in corner box) OPV/IPV (If oral vaccine, indicate OPV in comer box) MMR MMR HAEMOPHILUS B (HIB) HEPATITIS B VARICELLA PNEUMOCOCCAL CONJ. OTHER (Specify): LEAD SCREENING (\$6 Years) TEST DATE: RESULT: | DTP/DTaP/Td/TD (If Td or D) | | MO/DAT/TK | MO/DAT/TK | WO/DAT/TR | MO/DAT/TK | | | | |
| OPV in corner box | | , | | | | | | | | |
| OPV in corner box) | OPV/IPV (If oral vaccine, indic | ate | | | | | | | | |
| HAEMOPHILUS B (HIB) HEPATITIS B VARICELLA VARICELLA PNEUMOCOCCAL CONJ. OTHER (Specify): LEAD SCREENING (\$\leq 6\$ Years) TEST DATE: RESULT: RESULT: RESULT: RUbella HEPATITIS B VIRUS (HBV) SCREENING Mumps Mu | | | | | | | | | | |
| HAEMOPHILUS B (HIB) HEPATITIS B VARICELLA PNEUMOCOCCAL CONJ. OTHER (Specify): LEAD SCREENING (\$\leq 6\$ Years) TEST DATE: HEPATITIS B VIRUS (HBV) SCREENING Anti-HBs: Ant | MMR | | | | | Document belo | w single antigen va | ccine receipt. | | |
| VARICELLA PNEUMOCOCCAL CONJ. OTHER (Specify): DEAD SCREENING (≤ 6 Years) HEPATITIS B VIRUS (HBV) SCREENING Screening Not Done | HAEMOPHILUS B (HIB) | | | | | | | | | |
| PNEUMOCOCCAL CONJ. OTHER (Specify): Measles Mumps | HEPATITIS B | | | | | | DATE | TITER | | |
| OTHER (Specify): Measles Mumps Mumps | VARICELLA | | | | | Hepatitis B | | | | |
| LEAD SCREENING (≤ 6 Years) TEST DATE: RESULT: RUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mumps Mumps RESULT: Rubella Ru | PNEUMOCOCCAL CONJ. | | | | | * Varicella | | | | |
| LEAD SCREENING (≤ 6 Years) TEST DATE: RESULT: Rubella | OTHER (Specify): | | | | İ | Measles | | | | |
| HEPATITIS B VIRUS (HBV) SCREENING Screening Not Done Anti-HBs: Negative Positive (If positive, patient is immune.) HbsAg: Negative Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): TB Treatment (✓ one): Not given Done Yes Reason: Not Done No | | | | | | Mumps | | | | |
| Screening Not Done Anti-HBs: Negative Positive (If positive, patient is immune.) HbsAg: Negative Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): Done Reason: Not Done Not Not Not Not Not Not Not No | LEAD SCREENING (≤ 6 Year | s) TEST DATE: | | RESULT: | | Rubella | | | | |
| Screening Not Done Anti-HBs: Negative Positive (If positive, patient is immune.) HbsAg: Negative Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): Done Reason: Not Done Not Not Not Not Not Not Not No | HEPATITIS B VIRUS (HBV) SCREENING | | | | | | | | | |
| □ Anti-HBs: □ Negative □ Positive (If positive, patient is immune.) □ HbsAg: □ Negative □ Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): □ Not given Reason: □ Not Done □ No | | | | | | | | | | |
| ☐ HbsAg: ☐ Negative ☐ Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) TUBERCULOSIS SCREENING BY EXAMINING HEALTH CARE PROVIDER | _ | | | | | | | | | |
| (To be done regardless of BCG history.) Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): TB Treatment (✓ one): □ Not given □ Done □ Yes Reason: □ Not Done □ No | ☐ HbsAg: ☐ Negative ☐ Positive (If positive, patient is infected with HBV and is infectious to contacts; needs HBV counseling.) | | | | | | | | | |
| Mantoux Skin Test Reaction (PPD) Chest X-Ray (taken in US) (✓ one): TB Treatment (✓ one): □ Not given □ Done □ Yes Reason: □ Not Done □ No | | | | | | | | | | |
| □ Not given □ Done □ Yes Reason: □ Not Done □ No | | | | | | | | | | |
| Reason: Not Done No | | tion (PPD) | • | (taken in US) (v | one): | | : (✓ one): | | | |
| Trouboni. | ■Not given | | | | | _ | | | | |
| ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | | _ | | | | | | | | |
| Detail / / | | | | | | | | | | |
| Given, not read | / | | | | | | | | | |
| Date Administered | Date Administered/ | | | | | | | | | |
| Non-TB Abnormality Confirmed Case | | | | | | | | | | |
| TB-Like Abnormality (must be in mm) Cavitation? | TB-Like Abnormality | | | | | | Infection | | | |
| Cavitation! Lifes Lino — | | | | | | | | | | |
| TB Clinic Referral TB Clinic Site Appointment Date | TD Clinic Deferred | TD Clinia Cita | | | | | Annelatar | at Date | | |
| | ☐Yes ☐No | 10 Cillic Site | | | | | Appointme | n Daie | | |

DOMESTIC HEALTH ASSESSMENT, Continued

| Name | (Last) | (Fii | irst) (Mi | ddle) | | | Alien No. | | | | |
|--|--------------------------------------|-----------------|--|-------------|---|---------------|-------------------------------------|----------------------|----------------|---------|------------------|
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| | | | INITE | TIMAL DADA | OITIO | OODEENIN | | | | | |
| Screening fo | r Intoctinal I | Daracitos: | INTE | STINAL PARA | SITIC | SCREENIN | G | | | | |
| □Not Don □Patient I □Screenir | e (not symp Refused ng Done/Pa | | ed: | | | | | | | | |
| │None │Ascar │Blastd │E.hist │Giard | ocystis tolytica | Treated: [| ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No | | Hookwo Strongyl Frichuris Other (s | oides | Treated: Treated: Treated: Treated: | □Yes □Yes □Yes | s ∏No s ∏No |) | |
| | | | | SCRE | ENING | | | | | | |
| Sexually Train | nsmitted Dis | sease? | If Yes, identi | | | | | Trea | ted | | |
| □Yes | □No | □N/A | | • | | | | | Yes | □No | |
| Pregnant | | | Vision | | Н | earing | | Oral | Exam | | |
| □Yes | □No | □N/A | □Normal | □Abnormal | | □Normal | Abnormal | | Normal | Abnorm | nal |
| □Yes | No | or Labs Orde | | | | | | | | | - - - - |
| Referrals Pro Ear, Nos OB/GYN Pediatric Urology Gastroin | se and Thro N cs | at - | | | | | | | | | |
| Neurolog Dermato Vision Hearing Dental Mental H Other: | ology Health | - | | | Langu | age of Interp | preter | | | | - - - |
| Telepho | | aff Interpreter | ☐ Contracted | Interpreter | Langu | age or mierp | netei | | | | |
| Name of Clin | | an interpreter | Contracted | | | | Telephone | Number | | | |
| Name of Exa | mining Phy | sician (Print) | | Signature | | | | | Screenin | ng Date | |